

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396147	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/10/2023
NAME OF PROVIDER OR SUPPLIER: VILLA CREST, LLC THE STATE LICENSE NUMBER: 24720201			STREET ADDRESS, CITY, STATE, ZIP CODE: 1451 FRANKSTOWN ROAD JOHNSTOWN, PA 15902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
F 0000	INITIAL COMMENT	F 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396147	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/10/2023
NAME OF PROVIDER OR SUPPLIER: VILLA CREST, LLC THE STATE LICENSE NUMBER: 24720201		STREET ADDRESS, CITY, STATE, ZIP CODE: 1451 FRANKSTOWN ROAD JOHNSTOWN, PA 15902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
F 0000	Continued from page 1 Based on a Follow-up Survey completed on February 10, 2023, it was determined that Villa Crest corrected the state and federal deficiencies cited during the survey of November 22, 2022, under the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000			

[illegible]



Certified End Page

VILLA CREST, LLC THE
STATE LICENSE NUMBER: 24720201
SURVEY EXIT DATE: 02/10/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY